MEDICAL POLICY

Excellus

SUBJECT: EMERGENCY CARE SERVICES	EFFECTIVE DATE: 05/09/12 REVISED DATE: 04/25/13, 04/24/14, 04/23/15, 04/28/16, 06/22/17, 04/26/18
POLICY NUMBER: 10.01.12 CATEGORY: Government Mandate	PAGE: 1 OF: 3

- ***If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.***
- ***If a commercial product, including an Essential Plan product, covers a specific service, medical policy criteria apply to the benefit.***
- ***If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.***

POLICY STATEMENT:

I. The Health Plan considers an emergency condition to be a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
   A. Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or
   B. Serious impairment to such person's bodily functions;
   C. Serious dysfunction of any bodily organ or part of such person; or
   D. Serious disfigurement of such person.

   Examples of medical conditions that are considered to be emergency conditions are heart attacks, poisoning and multiple trauma. Conditions not ordinarily considered to be emergency conditions are head colds, flu, minor cuts and bruises, muscle strain and hemorrhoids.

II. Emergency services to treat an emergency condition are **eligible for coverage** regardless of whether the services are provided by a participating provider or a non-participating provider.

III. The Health Plan does not require prior-authorization for services for emergency conditions.

Refer to Corporate Medical Policy #11.01.15 regarding Medically Necessary Services.

POLICY GUIDELINES:

I. Member cost-sharing for emergency services is the same whether services are rendered within or outside of the provider network.

II. Some self-funded plans require the Health Plan to conduct retrospective review of the medical necessity for emergency care services. Please refer to the member's summary plan document or benefit booklet for specific plan information.

   Please note, New York State regulations do not apply to self-funded Plans and the emergency provisions of the Patient Protection and Affordable Care Act (PPACA) only apply to non-grandfathered, self-funded plans.

III. If additional clinical information is needed in order to determine whether or not the member's condition is truly emergent the Health Plan requests it from the billing facility and allows the appropriate timeframe according to regulatory requirements for response. When the information is received, the Health Plan conducts a medical necessity review based on the member's presenting symptoms and the prudent layperson standard for the emergency services. If no information is received within the regulated timeframe, the Health Plan conducts a medical necessity review based on the clinical information that is has received up to that point (e.g. the original claim) and the prudent layperson standard. Members have the right to appeal denied emergency services claims.

IV. In general, follow-up care to an emergency room visit (e.g. physical therapy) is not considered an emergency service to treat an emergency condition.

V. All members, including Medicaid Managed Care and Child Health Plus members, are held financially harmless for Emergency Department visits for emergency conditions. Members may not be billed.

DESCRIPTION:

New York State Insurance and Public Health Laws consider an emergency condition to be a medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; (4) serious disfigurement of such person; or (5) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

The laws also require that emergency services rendered to an insured shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.

"Emergency services" means with respect to an emergency condition: (i) a medical screening examination, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient. For the purpose of this definition, "to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a facility or to deliver a newborn child (including the placenta).

Coverage subject to the Federal Patient Protection and Affordable Care Act (PPACA) and New York State law must not impose limitations on emergency treatment which are more restrictive for out-of-network care than for emergency treatment rendered at an in-network facility. In addition, PPACA and New York State law do not allow insurers to require prior authorization for in-network or out-of-network emergency services. Finally, under New York State law, insurers are required to ensure that members are held harmless for emergency services.

CODES: Number Description

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

CPT: Several

HCPCS: Several

ICD10: Several

REFERENCES:

Federal Patient Protection and Affordable Care Act, Section 2719A.

New York State Insurance Laws. §4900 (c) and §4902 (a) (8).

U.S. Congress. Social Security Act, Section 1867, §1395dd.

KEY WORDS:

Emergency services/care.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based upon review, emergency care service is not addressed in a National or Local Medicare coverage determination or policy.